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Religious Coping and Spiritual Struggle Among Emergency Room Patients With Suicidal Intent

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Previous literature has shown religion and spirituality to be protective factors for depressive symptoms and suicidal ideation, and that spiritual struggle is associated with increases in suicidal ideation. However, in some cases, positive religious coping may also be associated with risk factors for suicidality. The present study explored aspects of spiritual struggle or religious coping that were spontaneously offered and noted in a medical record during a standard emergency room risk assessment involving the Collaborative Assessment and Management of Suicidality (CAMS). Among 839 archival records from emergency department settings in Yamhill County, Oregon, in 2015 and 2016, only 36 interviews met criteria. It was hypothesized that those with expressed spiritual or religious struggle would indicate a higher risk for suicide through self-report compared with those who express positive religious coping. The current study found no association between self-report of suicidal intent severity and style of spiritual or religious coping, perhaps in part because the number of interviews that met criteria were far fewer than expected. Several possible explanations are considered.

Keywords: suicidal intent, suicide, religious coping, spiritual struggle

Suicide is among the top three universal causes for death among 15- to 44-year-olds (Wu, Wang, & Jia, 2015). As of 2012, it is estimated approximately 800,000 suicide deaths occur worldwide each year, averaging approximately 11 individuals for every 100,000. By comparison, suicide outnumbers the average number of homicide deaths globally by approximately 2:1 (World Health Organization, 2012). One protective factor against suicide attempts, suicidal ideation, and related depressive symptoms is religiosity and spirituality, which has been identified repeatedly in the literature (Dervic et al., 2004; Dew et al., 2010; Miller et al., 2012; Nonnemaker, McNeely, Blum, & the National Longitudinal Study of Adolescent Health, 2003; Rasic et al., 2009; Rosmarin, Bigda-Peyton, Ongur, et al., 2013).

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Although they are often referred to interchangeably, religion and spirituality represent related but different human experiences. Koenig (2012, p. 3) referred to spirituality as "the personal quest for understanding for life's ultimate questions and the meaning and purpose of living." Spirituality is a common existential pondering that may increase during times of crisis. Religion is defined as "an organized system of beliefs, practices, rituals, and symptoms designed to facilitate closeness to the sacred or transcendent" (Koenig, 2012, p. 2). Religion is an important aspect of culture globally in that it establishes social power structures, communities, and a clear moral code that enable individuals to increase conformity to the desired behaviors to gain deeper meaning of existence. This established code and structure also provides a guide to corrective responses and potential increased support to those who stray (Agorastos, Demiralay, & Huber, 2014).

In the United States, approximately 52% identify religion as "very important," and about three out of four Americans identify as "Christian" (Gallup, 2015). Approximately 22.8% of Americans identify as unaffiliated including such categories as "atheist," "agnostic," or "nothing in particular" (Pew Research Center,

2015). While mainstream Christian denominations have declined from 78.4% in 2007 to 70.6% in 2014 (Pew Research Center, 2015), during the same time period research has emerged showing that individuals who engage in spiritual and religious practices tend to show increased health behaviors (Guilfoyle & St Pierre-Hansen, 2012; Koenig, 2012; Nonnemaker et al., 2003), increased life expectancy (Hummer, Rogers, Nam, & Ellison, 1999), and increased work performance (Newport, 2013).

When considering suicidality, religion and spirituality (R/S) warrant consideration for at least three reasons. First, R/S appear to be related to depression, which is, in turn, is related to suicidal thoughts and behaviors. Second, R/S may be a direct protective mechanism for suicidal thoughts and behaviors. Third, how a person relates to religious or spiritual beliefs, either by spiritual struggle or by religious coping, may indicate a warning sign for suicidality.

Religion, Spirituality, and Depression

Many studies have shown R/S to be protective factors for depression (Maselko, Gilman, & Buka, 2009; Miller et al., 2012; Portnoff, McClintock, Lau, Choi, & Miller, 2017; Schettino et al., 2011). A large meta-analysis by Smith, McCullough, and Poll (2003) showed religion had a small but significant inverse relationship with depression. More recent studies affirm this relationship between depression, religion, and spirituality. For example, after controlling for substance abuse and social support, items involving loss of faith, lack of forgiveness, negative religious support, and negative religious coping retained significant positive correlation with depression among an adolescent inpatient population (Dew et al., 2010). Moreover, loss of faith predicts less improvement in depression scores over 6 months and may be a marker of poor prognosis among youth suffering from depression (Dew et al., 2010).

A longitudinal study of women in families with history of depression indicates that those who attended church regularly show fewer symptoms of depression and are less likely to have a need psychopharmacological intervention for depression independent of their social adjustment (Barton, Miller, Wickramaratne, Gameroff, & Weissman, 2013). Miller and others (2014) found for this same population, studied via magnetic resonance imaging (MRI) twice in 5 years, that those individuals who indicated religion as "more important" showed an increase in cortical thickness in left and right parietal and occipital regions of the brain, as well as the mesial frontal lobe of the right hemisphere and the cuneus and precuneus in the left hemisphere. Their findings showed a 90% decrease in the risk of depression independent of family history.

The effects of religious involvement may be different among various racial groups. For example, church attendance and involvement are related to less reported depression overall among African Americans in comparison to other racial groups (Hudson, Purnell, Duncan, & Baker, 2015; Reese, Thorpe, Bell, Bowie, & LaVeist, 2012). Church attendance multiple times a week has also been shown to be associated with overall life expectancy across ethnicities; however, among African Americans, church attendance is associated with up to 14 more years of life expectancy (Hummer et al., 1999).

Within an inpatient geriatric population, intrinsic religiosity is associated with lower depression scores over time (Payman & Ryburn, 2010). Among an inpatient psychiatric population of those with psychosis, Rosmarin, Bigda-Peyton, Ongur, et al. (2013) found that those with a belief in God were associated with improved treatment outcomes, decreased behaviors of self-harm, decreased symptoms of depression, and an overall sense of well-being over time.

Religion, Spirituality, and Suicide

Whereas the relationship between R/S and depression is increasingly clear, studies investigating R/S and suicidality reveal mixed findings. Various perspectives are important to consider, including religion as a motivating factor for suicide. Huguelet et al. (2007) found within a population of patients with a diagnosis of schizophrenia or schizoaffective disorder religion has no significant effect on suicidality, although 25% reported it to be protective. Conversely, approximately 1 in 10 inpatients cited religion as an incentive for suicide, indicating comfort in the hope of life after death. In a population of clinically depressed patients, high religious involvement was associated not only

with increased suicide attempts, but also increased hospitalizations, antidepressant switches, prescription of tricyclic antidepressants, family history of depression, and a comorbidity of obsessive–compulsive disorder (Azorin et al., 2013).

Lawrence and others (2016) found religious affiliation, attendance, and the self-reported importance of religion to be associated with increased suicide attempts and ideation in a population of 321 adults of inpatients and outpatients diagnosed with major depression or bipolar disorder. In contrast, Svob, Reich, Warner, and Weissman (2016) reported that religious affiliation mitigated the likelihood of suicide completion among children and adolescents.

The relationship between suicide and religion may vary with culture. Wu and others (2015) suggests that results of religiosity vary between Western and Eastern culture. A psychological autopsy report of Chinese men who had died by suicide in a rural province showed religiosity to be higher among those who died than among the controls (Zhang, Xiao, & Zhou, 2010). In contrast, Wu and others (2015) suggests that religion may serve more of a protective function in Western civilization's religiously homogeneous communities, and in populations of older adults. Consistent with this, Dervic and others (2004) reported the number of suicide attempts across the life span is mitigated among religiously affiliated inpatients. In addition, for individuals with a mental illness who identified as spiritual or religious or both, overall decreased suicide attempts were found independent of the effects of social support (Rasic et al., 2009).

Religious Coping

In general, religious practice is associated with increases in meaning, control, and comfort in stressful situations (Pargament, 1997). When religion fails to provide these, individuals may choose to transform their religious practices into coping styles. Religious coping has been a topic of extensive study. Religious coping, first conceptualized by Pargament (1997), is defined as "the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances" (Koenig, Pargament, & Nielsen, 1998, p. 2). In this way, individuals engage collaboratively with their deeper beliefs in god, spirit, or other deeper power to facilitate problem solving processes and enhance empowerment (Pargament, 1997).

Religious coping is divided into various subconstructs, including positive and negative coping. Positive and negative coping generally lead to positive and negative psychological adjustment, respectively (Ano & Vasconcelles, 2005; Pargament, Koenic, Tarakeshwar, & Hahn, 2004; Terreri & Glenwick, 2013). Positive religious coping leads to a collaborative process with God and spiritual leaders and increases the experience of empowerment that may fuel a recovery process through the troubling situation (Yangarber-Hicks, 2004).

Individuals differ in religious coping and do not uniformly utilize positive or negative coping for specific situations. Indeed, many utilize a combination of both positive and negative coping strategies for a given situation (Schottenbauer, Rodriguez, Glass, & Arnkoff, 2006).

The concept of negative religious coping is closely aligned with the newer construct of religious and spiritual struggle (Exline, Pargament, Grubbs, Yali, & Piedmont, 2014; Exline & Rose, 2013). Even a decade ago, McConnell, Pargament, Ellison, and Flannelly (2006) identified negative religious coping as a form of spiritual struggle that has significant links to anxiety, depression, paranoid ideation, obsessive-compulsiveness, and somatization. Religious and spiritual struggles include struggles with the divine or the demonic, interpersonal or intrapersonal challenges with a higher power or members of the faith, moral struggle, struggle with doubt, or struggle for ultimate meaning (Exline et al., 2014). The purpose of the current study was to explore whether these beliefs bear some weight in the decision-making process of suicide.

Negative religious coping and spiritual struggle have been associated with increased suicidal ideation (Ahles, Mezulis, & Hudson, 2016; Currier, Smith, & Kuhlman, 2017; Henslee et al., 2015; Lee, Nezu, & Nezu, 2014; Rosmarin, Bigda-Peyton, Kertz, et al., 2013; Stratta et al., 2012; Trevino, Balboni, Zollfrank, Balboni, & Prigerson, 2014). In populations exposed to a recent natural disaster, suicidal ideation was associated with an increase in spiritual struggle (Stratta et al., 2012). Similarly, Currier et al. (2017) found negative religious coping to be

linked with risk for suicidal behaviors among U.S. veterans involved in the Iraq and Afghanistan conflicts. This indicates that severe and prolonged environmental stress may challenge spiritual or religious beliefs and thus become a risk factor for suicide. Among patients with advanced stages of cancer with a life expectancy of 6 months or less, spiritual struggle is robustly correlated with suicidal ideation even after controlling for mental and physical health, self-efficacy, secular coping, social support, spiritual care, global religiousness and spirituality, and positive religious coping (Ahles et al., 2016; Trevino et al., 2014). Similar associations between increased suicidal ideation and negative religious coping have been reported among a population of individuals who had AIDS or the HIV. In contrast, positive religious coping was associated significantly with positive affect and life satisfaction, although it was not associated with overall depressive symptoms or perceived quality of life (Lee et al., 2014). In a population with severe and persistent mental illness, Rosmarin, Bigda-Peyton, Kertz, et al. (2013) reported that positive religious coping was associated with significant reductions in depression and anxiety among patients with psychosis, and spiritual struggle was associated with increases in suicidal ideation, depression, anxiety, and well-being. This demonstrates that those patients with psychotic pathology, spiritual struggle may be a motivating force for suicide. As an alternative, positive religious coping may be a protective factor.

Collaborative Assessment for Management of Suicidality

Harris, McLean, Sheffield, and Jobes (2010) reported that nearly all 1,000 suicidal individuals in their study engaged in an internal debate, to live or to die. This internal debate may often include a behavioral component, including researching plans or connecting with other suicidal persons online. Those afflicted by suicidal ideation may be ineffectual in engaging cognitive faculties to the debate because of mental illness (Jobes, 2012). The Collaborative Assessment for Management of Suicidality (CAMS) includes a mechanism to have patients complete two columns to identify ambivalence. These columns include reasons for living and reasons for dying. The CAMS is an assessment and intervention created to increase ambivalence and to engage suicidal patients in rational conversation through therapeutic alliance and enhanced coping (Jobes, 2012).

It is worth noting that the relationship between religion, spirituality, and reasons for living and dying is not a simple one. On the surface it might appear that religion gives hope, and hope is a reason for living, so religion should be a reason for living. But certain religious beliefs, such as the belief in a peace-filled afterlife, might also make a despairing person more inclined to consider suicide. Lusk, Dobscha, Kopacz, Ritchie, and Ono (2017) interviewed military veterans and concluded there is a "complex and diverse relationship between spirituality/religion and suicidality" (p. 1).

The present study explored the spontaneous identification of religious and spiritual factors that are listed as reasons to live or die on completed CAMS among a population of patients who have visited the emergency department in Yamhill County, Oregon, within a 2-year span. The religious or spiritual content was identified and coded as positive religious coping or spiritual struggle. It was predicted that both positive religious coping and spiritual struggle would contribute to predicting overall self-reported suicide risk.

Method

Participants

We explored archival data from previous CAMS assessments from January 2015 to December 2016. Records were de-identified and coded according to their initials and date of birth. Individuals with repeated CAMS administrations were selected only once for inclusion in the data set (the administration selected was chosen by random number generator). Inclusionary criteria involved the completion of CAMS Risk assessments of suicidal individuals by a clinician who recorded a religious or spiritual issue, either as a reason to live or die. Of the 839 archived interviews, only 36 (4.3%) of interviews met the criteria, which is far lower than anticipated. Of the 36 participants, 10 were identified on the CAF as male (29%) and 25 as female (71%). The ethnicity of the participants included 82.9% European American, 5.7% Hispanic, 2.9% African American, 2.9% Asian

American, and 5.7% other. Of the 36 individuals, 13 individuals were negative for any toxicology. Of the toxicology screens, 22.9% of the participants were positive for alcohol use, 31% positive for THC, 20% positive for benzodiazepines, 9% positive for opioids, 11% positive for amphetamine, 5% positive for oxycodone, and 3% positive for some other potential intoxicant. Among the participants, 71% (25) met criteria for major depressive disorder, 37% (13) for a substance use disorder, 8.6% (3) for trauma-related disorder, 14% (5) for anxiety disorder, 11% (4) for psychosis, 2.9% (1) for dementia or other neurological disorder, and 2.9% (1) for other disorder.

Instruments

The CAMS is a program of therapeutic intervention developed by Jobes (2012) specifically developed to treat suicidality. The Suicide Status Form (SSF) is the core assessment used to indicate severity of suicidal symptoms at the initial intake, as well as a method to track intensity throughout the CAMS program of therapeutic treatment (Corona et al., 2013). In previous studies, Jobes, Jacoby, Cimbolic, and Hustead (1997) demonstrated significant pre/post within-group differences using the SSF among a group of 106 college students with suicidality. The SSF shows acceptable to good test–retest reliability and reasonably good convergent and criterion-related validity. The SSF form consists of several items related to suicidal symptoms and thought processes. The patient reports the intensity of specific drivers of suicide, including psychological pain, stress, agitation, self-hatred, and overall risk of suicide, as well as a qualitative descriptions of reasons for living (RFL) and reasons for dying (RFD; Jobes, 2012).

For additional data regarding any religious or spiritual content, the standard emergency room interview report known as the Crises Assessment Form (CAF) was considered. All qualified mental health professionals were trained by Yamhill Community Mental Health to gather the same pertinent information to determine the level of risk a patient present to him or herself or to others. The CAF is a tool to guide this process and to organize the note written after the interview. The CAF includes demographic information, presenting concern, and occasionally will identify the spiritual orientation of the patient. The Suicide Adult Assessment Protocol (SAAP; Fremouw, Tyner, Strunk, & Mustek, 2005) is a measure of suicide risk embedded within the CAF as a way of gathering the pertinent contextual, historical, and demographic risk factors of the patient as a way of determining the level of risk ranging from low to high. For the purposes of the current study, only those recorded content items in direct reference to religious or spiritual content were recorded from the CAF.

Procedure

Data were collected from the standard intake interview questions within the CAF as well as the CAMS SSF, including spiritual orientation, psychological distress, stress, agitation, self-hatred, and overall self-reported risk of suicide. Any R/S content recorded in the standardized interview was also considered. For the purposes of this study, R/S content included all references to God, Jesus, spirit, afterlife, heaven, hell, demon, angels, the universe, karma, mother nature, or other related spiritual, sacred, or supernatural content. Data were recorded under date of interview and medical record number and then de-identified using only the last four numbers of the medical record number prior to data analysis.

Grounded theory was utilized to code the content expressed in the qualitative sections of the CAMS of the SSF within the section for RFLs and RFDs. Tables 1 and 2 display the categories that were developed by a team of five research assistants. Overall, the five raters agreed 75.2% of the time on the categories for RFLs and 75.6% of the time for RFDs.

Results

Of the 839 archived interviews, only 36 (4.3%) of interviews met the criteria ($N = 36$). The low pool of participants foreclosed options to complete a regression analysis. A series of independent samples t tests were conducted instead. There was no significant difference in reported suicidal intent between those who identified positive religious coping as a reason for living, $M = 2.62$, $SD = 3.85$, $N = 17$, and those who did not identify positive religious coping factors as an RFL, $M = 3.14$, $SD =$

Table 1
Interrater Reliability for Reasons for Living (RFLs)

Reasons for living	Occurrence in sample	Average interrater reliability
Close family relationships	25	92.8
Social support	11	57.5
Divine being	11	83.3
Faith community	6	71.1
Religious practices, beliefs	5	57.7
Fear (death, consequences)	3	86.6
Pets, animals	4	95
Care for self (self-care, goals, future plans)	6	80
Care for others (service, not wanting to hurt people)	6	58
Aesthetics (art, beauty, music)	3	70

Note. Five raters were used to determine what factors applied to each patient who expressed RFL.

3.59, $N = 14$; $t(29) = .390$, $p = .93$, *ns*, Cohen's $d = 0.14$. Also, no significant difference was found in the reported suicidal intent level for those who identified positive religious coping factors as an RFD, $M = 3.50$, $SD = 4.14$, $N = 8$, and those who did not identify positive religious coping as a reason for dying, $M = 2.63$, $SD = 3.58$, $N = 23$; $t(29) = 0.57$, $p = .35$, *ns*; Cohen's $d = 0.22$). Neither effect size was found to be meaningful according to Cohen's (1988) convention. Similarly, there was not a significant difference in the reported suicidal intent level for those who identified spiritual struggle as a reason to die, $M = 0.25$, $SD = 0.50$, $N = 4$, and those who did not identify spiritual struggle factors as a reason to die, $M = 3.24$, $SD = 3.79$, $N = 27$; $t(29) = 1.55$, $p = .132$, *ns*; Cohen's $d = 1.10$. The effect size for this analysis exceeded Cohen's (1988) convention for a large effect size, but caution should be taken in interpreting this finding because of the low sample size in the analyses. No participants expressed any items related to spiritual struggle as a reason to live.

Discussion

The original purpose of this study was to determine whether positive religious coping or spiritual struggle influenced the severity of reported suicidal intent. Unexpectedly, the results of this study were inconclusive because of the limited number of participants for whom religious or spiritual content was recorded within their risk assessment. Several possible explanations are presented here.

Table 2
Interrater Reliability for Reasons for Dying (RFDs)

Reasons for dying	Occurrence in sample	Average interrater reliability
Escape physical suffering	6	72.5
Escape psychological suffering	12	63.2
Reunion with loved one	8	95
Anticipating positive after life	2	73.3
Religious trauma	1	100
Burden to others	5	92
Shame and failure	10	76.4
Anger toward others	1	80
Lack of resources	2	40
Lack of meaning	3	63.3

Note. Five raters were used to determine what factors applied to each patient who expressed RFD.

Explanation 1: Patients Have Little or no Inner Experience of Religion or Spirituality and Therefore do not Express any Related Content

It is possible that most individuals presenting to an emergency room setting for suicidality have few religious or spiritual beliefs that are related to drivers for suicide or as a protective support. The role of religion and spiritual beliefs in depression has been evident in the literature, but the research about the role of religious and spiritual beliefs within a population of individuals expressing severe suicidality is less known. It may also be that for this particular population, spiritual and religious factors play no role in either driving suicidality or providing a protective mechanism.

It is important to consider the regional implications of the sample used for this study. A 2009 Gallup poll suggests that approximately 42% of U.S. residents attend religious services weekly or almost weekly, but this varies widely from state to state, from 63% (Mississippi) to 23% (Vermont). Oregon, where this study was conducted, is among the least religious states in this survey, with 31% attending religious services regularly in the Gallup poll (Newport, 2010). Thus, even if this explanation is reasonable for this sample, it may not be equally reasonable in other geographic and cultural contexts.

It may also be useful to consider the relative salience of positive and negative religious coping. Among military veterans, Currier et al. (2017) found positive religious coping to be more common than maladaptive religious coping, but also noted that positive religious coping is not associated with suicidal behavior. In contrast, negative religious coping was associated with suicide. It seems possible that positive religion coping is more prevalent and salient to individuals prior to suicidal ideation—as they are dealing with depression or other challenges in life—but as they become suicidal, their adaptive religious coping becomes less prominent. Negative religious coping appears to be related to suicidality, but perhaps not closely associated with the normative forms of religious and spiritual beliefs and practices that are part of everyday experience.

Explanation 2: Patients Have an Inner Experience of Religion and Spirituality and Express Related Content, but These are not Recorded Within Risk Assessments by Interviewers

One possibility is that very little religious and spiritual content was documented despite what may have occurred in the actual clinical interview. Previous literature has indicated that highly educated individuals tend to be less religious and less inclined to consider religious and spiritual factors in daily life (Delaney, Miller, Bisonó, & Roberts, 2007; Shafranske & Malony, 1990). In institutions and settings of highly educated individuals, secularity is the norm, and religious or spiritual content may be more likely to be ignored, disregarded, pathologized, or even disrespected. Of note, all the emergency room clinicians were doctoral students at an America Psychological Association (APA)-accredited graduate program in clinical psychology. This doctoral program is affiliated with an evangelical Quaker denomination and students are required to take several courses related to engaging with spiritual and religious issues in their personal life as well as professional. But even in religiously oriented training programs graduate students in clinical psychology may attend less to R/S than would be optimal. Fisk and others (2013) have shown that in later years, students in religiously oriented doctoral programs identify less reliance on God and religious practice than they showed early in training. As an alternative, it may be that as consultants from a Christian university, interviewers are aware that documentation involving religious or spiritual content may be disregarded among the highly educated professionals also involved in the hospital setting—physicians, psychologists, nurses, and psychiatrists.

Explanation 3: Patients Have an Inner Experience of Religion or Spirituality but Choose not to Express Related Content Because of Inhibiting Factors

Participants may be reluctant to share content related to religion and spirituality for a variety of reasons. It is culturally evident that within most societies of the United States of America there exists a distinct separation between religious spaces and secular spaces. Spaces desig-

nated for specific uses may decrease the likelihood of expressed behaviors that are not consistent with the role of the environment. In addition, policies of designated spaces may decrease nonnormative social behavior. The medical environment communicates specific expectations of behavior and may include a metacommunicated belief that personal religious and spiritual beliefs are unwelcome or simply required to be kept silenced. Miller (2015) proposes in a TED talk that medical settings provide anesthetic, which not only numbs pain but also removes reminders of those aspects of daily life that remind a person of their values, beliefs, and personal meaning. In other words, things related to aesthetic art, religion, personal meaning, may be absent from a hospital to better serve utility and purpose of medical procedure. If the risk assessment was completed within a place of faith practice, soft room with art, or in the presence of a chaplain or clergy member, an individual may be more likely to express religious or spiritual content because the environment will provide signals that personal expressions of beliefs are congruent with the environment, and it is more likely that these beliefs will be received with respect. For example, Budd (1999) collaborated with chaplains in the U.S. Air Force to develop an effective suicide prevention effort for Air Force personnel (see also Budd & Newton, 2005).

In addition, it may be that participants do not express personal religious or spiritual beliefs unless directly prompted within the risk assessment. Interviewers may not prompt individuals about their spiritual or religious beliefs believing that the patient will spontaneously offer content if it is important. This may be reflective of personal beliefs and/or time constraints of the interviewers.

One possibility for this may involve the belief of the interviewer that religious or spiritual beliefs have no influence on the severity of expressed suicidality and such a conversation may be lengthy and not beneficial to the patient. Another possibility may be because of the belief that the risk assessment may be sidetracked or hijacked to a discussion about religion or spirituality in a way that is unhelpful to the purpose of the assessment. Patients may respond in overly positive or negative ways to the interviewer when religious or spiritual questioning occurs, which may alter the appropriate level of rapport necessary to complete a thorough determination of the patients' needs.

Implications and Limitations

Although it is not possible to determine which of these three explanations best accounts for the lack of religious and spiritual content in the archival data used for this study, both research and clinical implications should be noted. Regarding research, further study need to explore the ways that religion and spirituality may protect or drive suicidality. In addition, it will be important to study how effectively and efficiently the religious and spiritual content of Emergency Department conversations are being recorded in medical records.

Regarding clinical implications, because medical settings include highly educated individuals who may be less likely than others to espouse personal R/S, it would behoove the medical community to have a validated screener or short assessment tool to identify how religious coping and spiritual struggle may be evidenced within expressed risk for suicidal behaviors. In this way, someone who does not espouse religious or spiritual belief may determine the level of danger for a person who identifies religious or spiritual content as a reason to live or die. Still, no assessment tool will replace a competent interviewer who is well informed of the literature for at-risk populations, warning signs, and environmental drivers which may propel an individual to consider ending their life prematurely. Interviewers need both training and encouragement to consider religious and spiritual assessment questions as part of risk interviews. In doing so, they may be able to capture components of a human life that seem to be either unrecorded, hidden, or ignored within many health care settings. This provides valuable information about how a patient functions, views the world, and experiences meaning.

The limitations of this study include generalizability concerns and interviewer differences. This study was conducted in rural Yamhill County, Oregon, which does not reflect the demographics of most counties in the United States. Yamhill County is 715.86 square miles with approximately 139 people per square foot. The largest towns are Newberg and McMinnville with many smaller towns, rural, and ag-

ricultural areas (U.S. Census Bureau, Yamhill County, Oregon, 2015). Yamhill County has an estimated population of 102,659 and is primarily European American with an estimated 91.9% identifying as White (U.S. Census, Yamhill County, Oregon, 2015). Within this population 87.5% of persons age 25 years or more graduated from high school, and 23.2% from Bachelor's or higher degree (U.S. Census Bureau, Yamhill County, Oregon, 2015). In addition, 10.9% are under 65 years with a disability, 11.7% without health insurance under age 65, and 13.3% (13,653) are living in poverty (U.S. Census Bureau, Yamhill County, Oregon, 2015). Given the high percentage of European Americans, economic disparities, and population of this county, the results of this study may not be well generalized to areas that are more urban, more rural, or more ethnically diverse.

Another limitation of the study relates to the interviewers. While all interviewers were employees of the George Fox Behavioral Health Consultation Team and were provided the same training, there is no guarantee each interviewer is asking the same questions or documenting the same information. Individual clinical judgment, personal differences, and individual countertransference in response to patients may influence what questions are asked and what information is recorded. Although all interviewers have had extensive coursework in spiritual and religious issues and questions related to religion and spirituality have been present on the CAF, it is not clear if interviewers are asking explicit questions related to religion and spirituality. Future studies should train interviewers specifically to ask religion and spirituality questions respectfully and to document the resulting conversations in relation to risk factors or warning signs.

Conclusion

Positive spiritual and religious experiences have been associated with mitigating depressive symptoms and increasing psychosocial adjustment, health behaviors, and life expectancy. The research concerning religious and spirituality and its relationship to suicidality is both limited and mixed. The purpose of the current study was to explore whether positive spiritual or religious coping or spiritual struggle influenced self-reported suicidal severity.

The results of this study offer no clarity to this question. Instead, more questions have been generated about the lack of documented religious or spiritual factors expressed by patients. It is possible that the interviewers did not record expressed R/S offered by patients experiencing suicidality, patients did not offer their R/S in the course of the interview, or patients do not prescribe to spiritual or religious beliefs, making R/S irrelevant to most risk assessments.

Spiritual and religious beliefs are often regarded as a diversity or cultural aspect of an individual and groups. Highly educated professionals may feel ill-prepared to engage these conversations and may be unfamiliar with how a practice or belief may interact in an individual's life. Developing useful screening measures to explore when a spiritual or religious belief may become a barrier or motivator to healthy recovery may be important to for further treatment and support of suicidal patients.

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